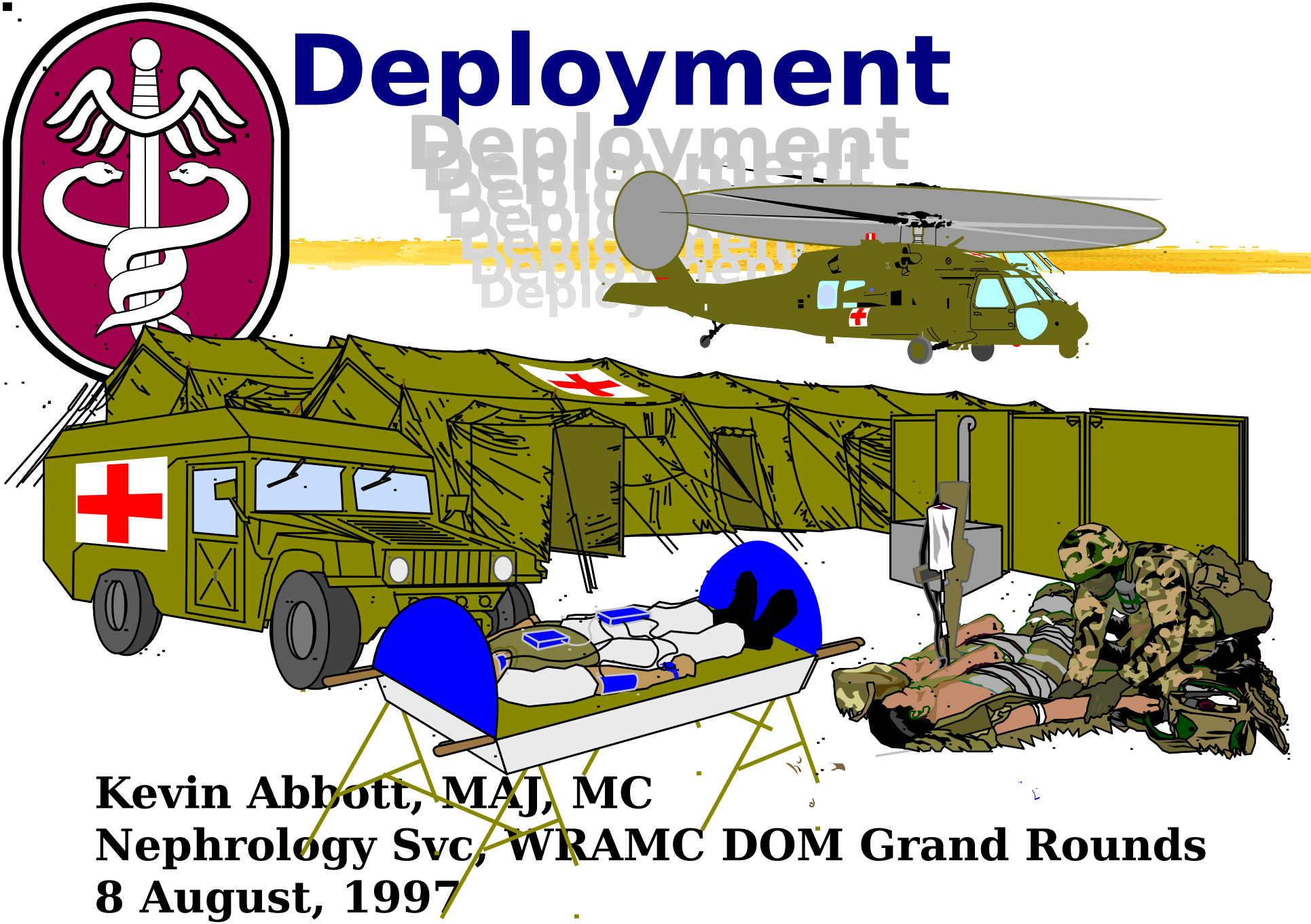
# Deployment



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**Nephrology Svc, WRAMC DOM Grand Rounds**
**8 August, 1997**

# Readiness

- Lack of readiness training has been cited as the most significant mission shortcoming in MEDCENS. Lack of integration between PROFIS units and integration between PROFIS units and cohesion and mission capability.

# Types of Deployments

- Combat (War)
- Operations Other Than War (OOTWR)

# Operations Other Than War

- Humanitarian Operations
- Peacekeeping missions

# Combat Operations

- Actual Combat
- Combat Readiness Operations (National Training Center, JRTC, REFORGER in Germany, TEAM SPIRIT in Korea, etc.)

# PROFIS

- The Professional Filler System--where you fit in as a medical professional
- Taken from the staff of a TDA facility (what's that?) to fill a slot in a TOE organization (what's that?)--when the unit goes to "war", so does the PROFIS filler.

# TDA vs. TOE

- TDA: Table of Distributions and Allowances--refers to authorized makeup of a fixed facility such as a MEDCEN or a MEDDAC
- TOE: Table of Organization and Equipment--Refers to a mobile facility designed for deployment, such as a medical company, combat support hospital, field or general hospital

# TOE vs. MTOE

- TOE is only the preliminary structure for deployment
- Its final version is MTOE, or modified table of organization and equipment

# Modularity and Task Forces

- Units are increasingly modular--a “slice” can be taken from an Army Unit, Air Force or Navy Unit, to form a **Joint Task Force**. They can even be combined with forces from different nations to form a **Combined Task Force.**
- While providing flexibility, it creates problems with cohesion and rating schemes.

# Impact of Modularity

- This means staff who are PROFIS to the same unit can be sent on entirely different missions to different locations for different lengths of time (eg, 61st ASMB in 1994):
  - Co A: Surinam for 4 weeks
  - Co. B: Panama for 3 months
  - Co. C: Cuba for 6 months
  - HQ Co.: Saudi Arabia for 2 weeks

# PROFIS Duties

- Ensure you are ready for deployment: have all vaccinations, dental work, legal and health issues addressed
- Periodic **SRP's** (Service Readiness Programs to check the above)
- Periodic training for weapons qualifications, DEPMEDS (Deployable Medical Systems) training.

# PROFIS Duties

- POM (Preparation for Overseas Movement)
- You may go through this yourself or be tasked to evaluate others

# Commander’s Staff

- S1 (or if commanded by a General Officer, G1, or in Joint Task Force, J1): Personnel
- S2: Intelligence (Thinks “Threat”)
- S3: Operations (usually the most challenging position)
- S4: Logistics
- S5: Civil Affairs

# Aeromedical Evacuation

# Theater evacuation policy

- The theater evacuation policy is established by the Secretary of Defense, with the advice of the Joint Chiefs of Staff, and upon the recommendation of the theater commander.
- The policy establishes, in number of days, the maximum period of noneffectiveness (hospitalization and convalescence) that patients may be held within the theater for treatment.

# Theater evacuation policy (cont'd)

- This policy does not mean that a patient is held in the TO for the entire period of noneffectiveness. A patient who is not expected to be ready for RTD within the number of days established in the theater evacuation policy is evacuated to the continental United States (CONUS) or some other safe haven.

# Theater evacuation policy (cont’d)

- This is done providing that the treating physician determines that such evacuation will not aggravate the patient's disabilities or medical condition.
- For example, a theater evacuation policy of 60 days does not mean that a patient is held in the theater for 59 days and then evacuated.

# Theater evacuation policy (cont'd)

- Instead, it means that a patient is evacuated as soon as possible after the determination is made that he cannot be returned to duty within 60 days following admission.

# Rules to live by

- NEVER leave your jacket/poncho behind (for cold/tropical climates respectively)
- Wherever you go, no matter how temporary the trip seems, BE PREPARED TO STAY SEVERAL DAYS (esp with Air-Evac trips)
- Always have canteen full, at least one spare MRE
- Emergency kit should include a packable foil blanket (for cold/desert climates), spare flashlight, and perhaps mountain stove with hexamine tablets.

# Non-Battle Injuries

- The most common cause of casualties in most conflicts throughout history
- Temperature related (frostbite, trenchfoot, immersion foot, heat exhaustion/stroke, food related, communicable (airborne)

# Prevention

- When sleeping in crowded tents, sleep from head to foot
- Place inspectors at front of food tents and WATCH all personnel wash their hands before entering. This reduced the 15th Evac's incidence of food poisoning to almost 0%, all neighboring units had 30%. THIS MUST BE COMMAND POLICY.
- Change your socks twice a day--remember Forrest Gump!

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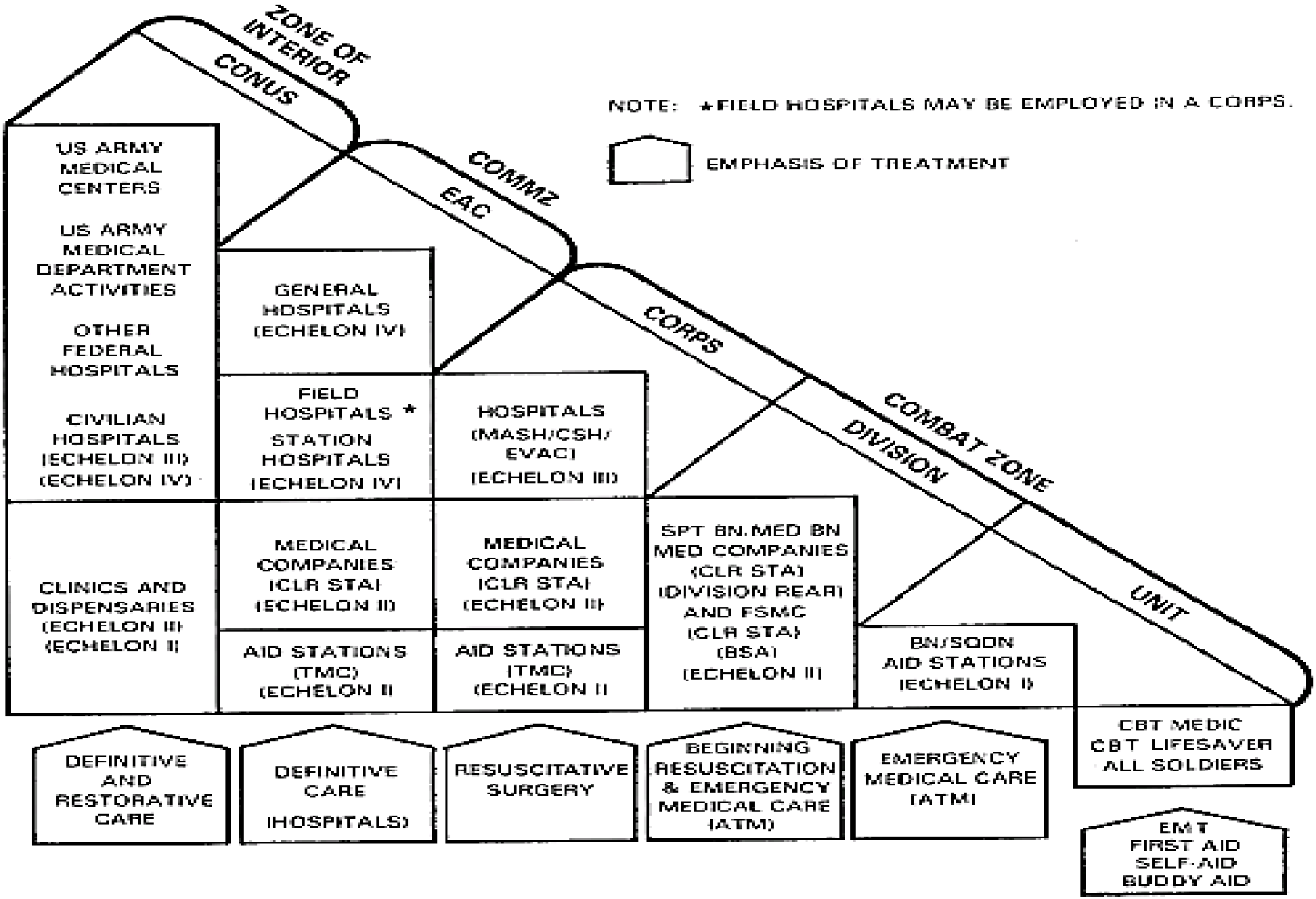
ZONE OF INTERIOR
CONUS
COMMZ
EAC
CORPS
COMBAT ZONE
DIVISION
UNIT
NOTE: *FIELD HOSPITALS MAY BE EMPLOYED IN A CORPS.
EMPHASIS OF TREATMENT
US ARMY MEDICAL CENTERS
US ARMY MEDICAL DEPARTMENT ACTIVITIES
OTHER FEDERAL HOSPITALS
CIVILIAN HOSPITALS (ECHELON III) (ECHELON IV)
GENERAL HOSPITALS (ECHELON IV)
FIELD HOSPITALS *
STATION HOSPITALS (ECHELON IV)
HOSPITALS (MASH/CSH/ EVAC) (ECHELON III)
CLINICS AND DISPENSARIES (ECHELON III) (ECHELON II)
MEDICAL COMPANIES (CLR STA) (ECHELON II)
MEDICAL COMPANIES (CLR STA) (ECHELON II)
SPT BN, MED BN MED COMPANIES (CLR STA) (DIVISION REAR) AND FSMC (CLR STA) (BSA) (ECHELON III)
AID STATIONS (TMC) (ECHELON II)
AID STATIONS (TMC) (ECHELON II)
BN/SQDN AID STATIONS (ECHELON I)
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DEFINITIVE CARE (HOSPITALS)
RESUSCITATIVE SURGERY
BEGINNING RESUSCITATION & EMERGENCY MEDICAL CARE (ATM)
EMERGENCY MEDICAL CARE (ATM)
CBT MEDIC CBT LIFESAVER ALL SOLDIERS
EMT FIRST AID SELF-AID BUDDY AID

*Figure 1-1. Echelons of medical treatment.*

*Table 4-1. Evacuation Patient Flow*

| EVACUATED FROM/TO | EVACUATION MEANS | RESPONSIBILITY | REGULATED BY |
|---|---|---|---|
| Point of injury/patient collecting point to BAS | Litter/Ground Ambulance | Maneuver Battalion Medical Platoon | BN Surgeon or PA |
| BAS to Medical Company | Ground/Air | Medical Company | Med Co Cdr |
| Med Co to Med Co | Ground/Air | Medical Company | DMOC |
| Med Co to MASH* (in Division Rear) | Air (Preferred) | Air Amb Co (DS) | DMOC |
| Medical Company to CSH/FLD | Ground/Air | Evacuation Battalion | DMOC and Group MRO |
| CSH to/from FLD | Ground/Air | Evacuation Battalion | GRP/BDE MRO |
| Area Spt Med Bn to CSH/FLD | Ground/Air | Evacuation Battalion | GRP/BDE MRO |
| CSH to GH | Air | Evacuation Battalion/USAF | GRP/BDE MRO, JMRO, or MEDCOM MRO |
| FLD to GH | Ground/Air | Evacuation Battalion | MEDCOM MRO |
| Area Spt Med Bn to GH | Air/Ground | Evacuation Battalion | BDE/MEDCOM MRO |
| GH to CONUS | Air/Surface | USAF/USN | BDE MRO/ ASMRO |

*Once stabilized, patient is MEDEVAC by air for definitive treatment.

**NOTE:** If available, wartime host nation transportation assets (rail ambulances, buses, aircraft, watercraft) may be used to evacuate patients from corps to corps, or corps to COMMZ.

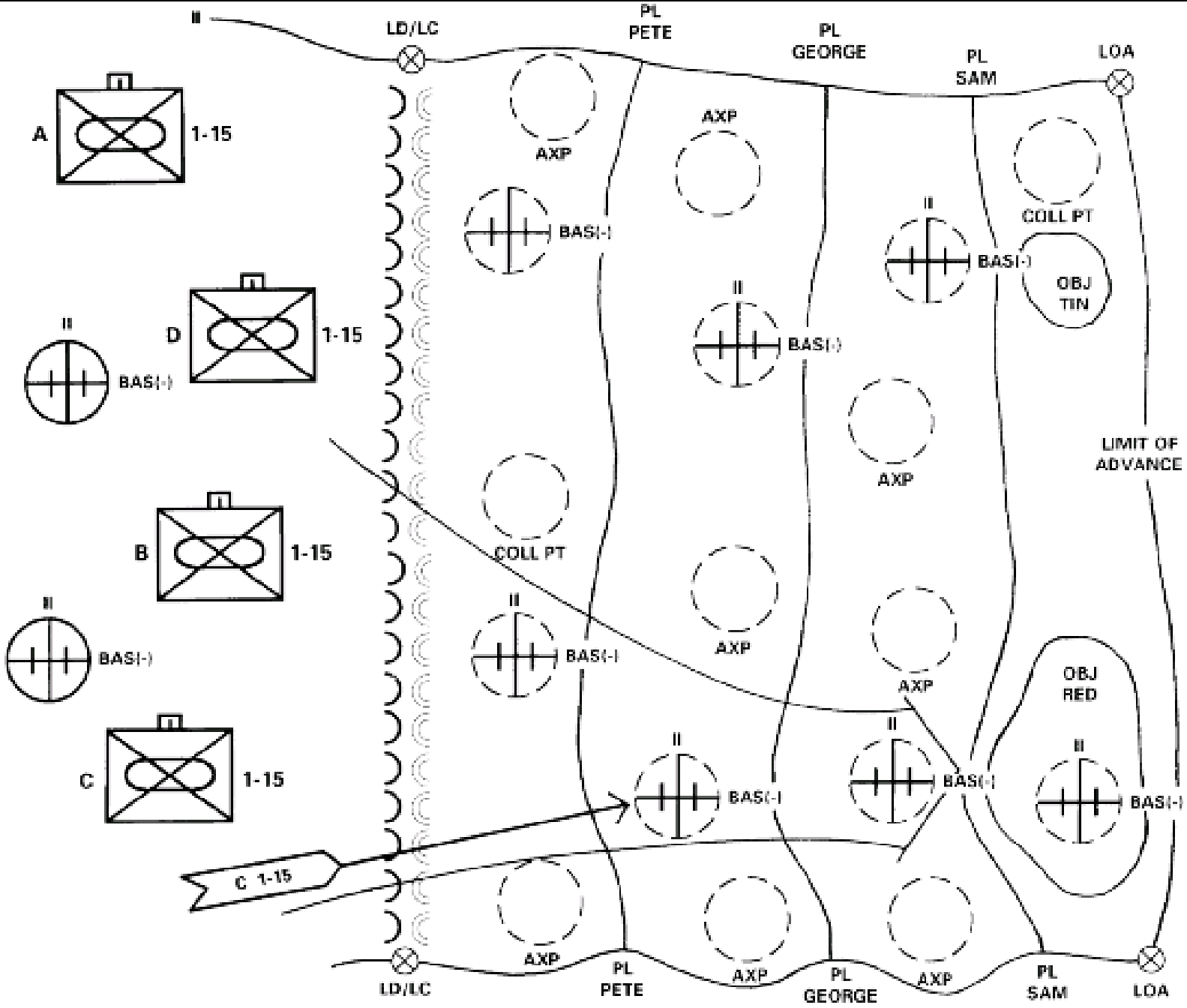
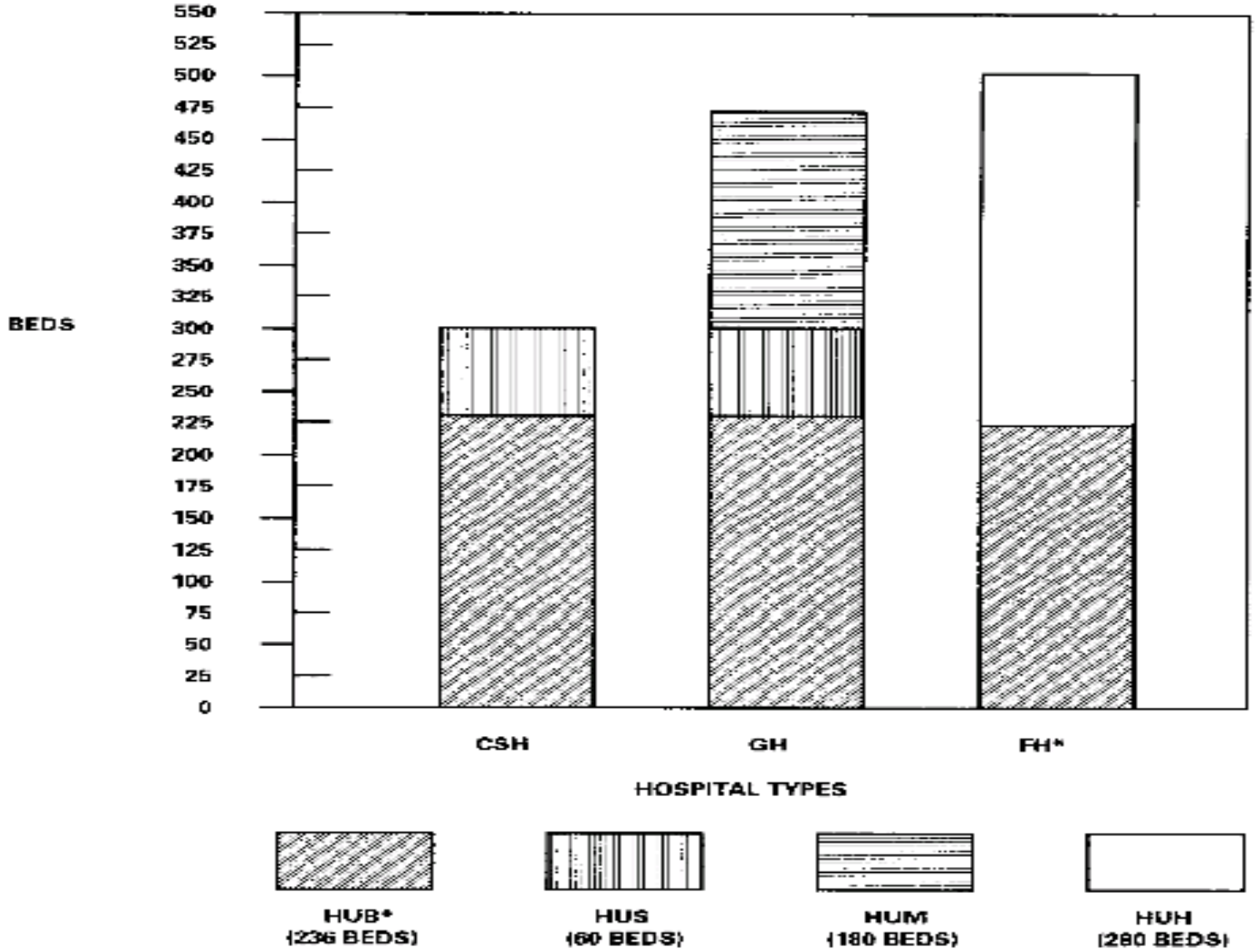



*Figure 4-1. Typical evacuation overlay.*




* ALTHOUGH THE HUB HAS 236 BEDS, WHEN IT IS USED AS THE BASE COMPONENT FOR THE FH, IT IS ONLY STAFFED TO PROVIDE HOSPITALIZATION FOR 224 PATIENTS. IN THE FH CONFIGURATION, THE HUB HAS TWO INTENSIVE CARE WARDS THAT PROVIDE CARE FOR UP TO 24 PATIENTS. BY CONTRAST, IN THE CSH AND GH CONFIGURATIONS, THE HUB HAS THREE INTENSIVE CARE WARDS THAT PROVIDE CARE FOR UP TO 36 PATIENTS. THIS IS THE REASON FOR THE 12-PATIENT DIFFERENCE IN THE FH CONFIGURATION.

## 2-4. Hospital Organization and Functions

The CSH is a modular-designed facility which consists of a HUB and HUS. It can be further augmented with specialty surgical/medical teams to increase its capabilities. It may become a designated specialty center as the work load or mission dictates (Figure 2-1).

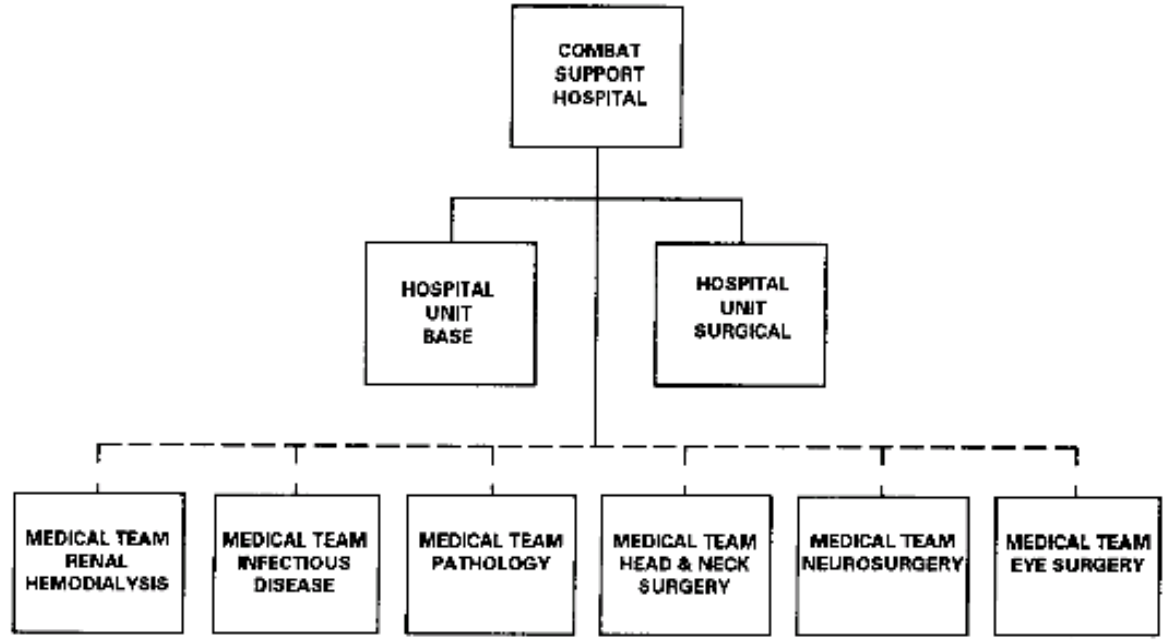

COMBAT SUPPORT HOSPITAL
HOSPITAL UNIT BASE
HOSPITAL UNIT SURGICAL
MEDICAL TEAM RENAL HEMODIALYSIS
MEDICAL TEAM INFECTIOUS DISEASE
MEDICAL TEAM PATHOLOGY
MEDICAL TEAM HEAD & NECK SURGERY
MEDICAL TEAM NEUROSURGERY
MEDICAL TEAM EYE SURGERY
NOTE: DEPENDING UPON OPERATIONAL REQUIREMENTS, THE MEDICAL AND SURGICAL TEAMS MAY OR MAY NOT BE ATTACHED TO THE INDIVIDUAL CLINICAL ELEMENT OF THE CSH.

*Figure 2-1. Combat support hospital organization.*